

Original Article



Family's Supportive Behaviors in the Care of the Patient Admitted to the Cardiac Care Unit: A Qualitative Study

Sima Babaei^{1*}, Shahla Abolhasani¹¹Department of Adult Health Nursing, Nursing & Midwifery Care Research Center, Isfahan University of Medical Sciences, Iran**Article Info****Article History:**

Received: 7 Jan. 2019

Accepted: 19 May 2020

e-Published: 1 June 2020

Keywords:Family, Supportive behaviour,
Coronary care unit, Patients,
Qualitative research**Corresponding Author:**

Sima Babaei,

Email: Babaei@nm.mui.ac.ir

Abstract

Introduction: A life-threatening illness can cause the involvement of family members and the imposition of psychological and physical stress on them. Certainly, the family is a very valuable resource in patient care and plays an important role in maintaining the emotional support and patient's recovery. The aim of this study was to explain the family members' supporting behaviors of the patient admitted to the cardiac special units.

Methods: This qualitative study was performed in the cardiac special units in Isfahan. The number of participants was 20, including 5 nurses, 8 family members, and 7 patients. The data were collected through interview and observation by purposive sampling. Then, the data were analyzed by Graneheim and Lundman's qualitative content analysis method. The study lasted 12 months.

Results: Data analysis showed that family's support can be classified into three levels, including support by the therapeutic alliance (attempts to console and reassure, restoration of self-esteem, diminishing patient's insensitivity, commitment to the patient, and visiting the patient), participatory information (obtaining reliable information from the nurse, active role in providing meaningful information about the patient's prognosis), practical and instrumental support (searching for economic support resources, providing the patient with the necessary equipment, trying to do the right care taking into account the family culture).

Conclusion: Understanding family's supportive behaviors can help improve counseling and planning for quality care of patients admitted to the cardiac care units (CCUs).

Introduction

A life-threatening illness can routinely impose huge physical and psychological burdens to the patient's family members. Undoubtedly, the family is a very fundamental resource in patient care,^{1,2} and plays a significant role in keeping emotional support and helping patient recovery.³ Among nursing audience groups, the family is described as both a care receiver and a care provider. Family is the most important human support system, and family members play an important role in caring of each other. This supportive role continues even when the person is hospitalized.⁴ Family members are faced with a variety of challenges against life-threatening illnesses that may either break their power of maintaining and deteriorating health or ultimately lead to their acceptance of and reconciliation with the problem. Different life-threatening conditions, such as myocardial infarction, cerebrovascular accidents, are examples of acute medical crises for family members.⁵

Coronary artery disease is a critical, sudden, unexpected, and often life-threatening illness that is stressful for both the patient and family members. In Iran, the prevalence of

cardiovascular disease is increasing, and more than a third of the mortality in the country is due to cardiovascular problems.¹ Anxiety is the overwhelming feeling of family members during a stay in an unknown fear, unexpected event, and uncontrollable condition.⁶ The anxiety becomes double particularly when the patient is admitted to stressful areas such as the emergency department.⁴ Nurses often work with family members who feel frustrated, feared, angry, failed, or confused. They usually do a lot of work to maintain and improve the health of the family members.⁶ Nurses have the opportunities to improve the health and idealize the family's function during their care period of the patient.⁷ Family members play an important role in improving the patient's mental health through having meaningful interaction with the patient and collaborating with the therapist in the care process, but their ability to support the patient may be affected due to the tensions that have been inflicted on the family itself.⁸

Patients sometimes receive cares or attentions from their families with the aim of improving their conditions, but such behaviours are not always helpful. For example, over-

protective behaviors or excessive worries about the patient may be considered as a helpful contribution from the family to the patient, while these interactions cause the patient to feel more physically inert and dependent. Psychosocial support of the patient is so important; it sometimes affects the instrumental support of the individual, but negative interactions and inappropriate communications can suppress the supportive actions.⁵ However, families can use appropriate supportive measures and positive and constructive coping mechanisms and techniques such as increasing the right to choose, inducing self-control, personal choices, expression of empathy, participation and affection, and closeness to the individual to promote their patients' support.⁹ Studies show that the basic needs of families for offering their special cares include ensuring adequate care, being beside the patient, having clear and accurate information, and having comfort and support.⁶ On the other hand, since nurses have a unique status to interact with patients and family members,¹⁰ they, in the form of family-oriented nursing interventions and advisors, can advise and guide family members and in particular carers to support their patients.¹¹ The results of studies show that patients who consider their family members as supportive, incentive, reassuring, and facilitating are more involved in positive health and behavioral conditions.⁷

Studies on the importance of supportive behaviors suggest that these behaviors by nurses and family members are various in different societies. In fact, the difference in behaviors is due to cultural differences; thus, specific behaviors can have different interpretations in different cultural contexts.¹² Generally, supportive behavior is still a phenomenon that is not well-defined, and the use of the term is still in a state of ambiguity.¹³ This confusion in understanding the composition of family support is associated with the need for a comprehensive understanding of the needs and experiences of family members about nursing supportive interventions. Totally, the interventions of family members can be considered as supportive only when they are meaningfully perceived by the care receivers. Thus, research on supportive behaviors within the intellectual framework of family members based on their needs and experiences on acute and special diseases in adults is of great importance. Indeed, it is necessary to conduct a qualitative study on the behaviors and experiences of these families. The purpose of this study was to explain the family members' supportive behaviors during the care process of the patient admitted to the cardiac care unit (CCU).

Materials and Methods

This study is a qualitative study with the aim of discovering and disclosing participants' experiences of supportive behaviors using the qualitative content analysis approach. Content analysis is a research approach and a scientific tool which provides a new cognition of events,

enhances the researcher's perception of phenomena, and identifies operational strategies.¹⁴ This study was conducted with the participation of family members, nurses, and patients in the CCU wards of the teaching hospitals of Isfahan University of Medical Sciences. The number of participants in this study was 20, including 5 nurses, 8 family members, and 7 patients. The duration of hospitalization was between 3 to 10 days. Due to the rich information and experiences of the participants, the sampling method was done purposefully. The first and second interviews were conducted with participants who had experience in providing support care for patients in the CCU. The data were collected by interview and observation. In qualitative research, researchers often face the challenge that respondents may respond more often based on their own ideas and, as a result, do not provide the researcher with rich and accurate information. For this reason, general questions were used in the first interview. In this regard, the first and second interviews were conducted without any particular structures and clearly defined questions. In this stage, the participants were only asked to speak about their experiences while caring of their patients. The researcher also allowed the participants to talk freely about their clinical experiences and asked them no guidance questions. However, after analyzing the first and second interviews, the subsequent interviews were semi-structured. The specific questions were about the conditions affecting the care and supportive behaviors of family members, the patient and the nurse, patient needs; and the type of supportive care carried out between the family caregiver and the patient. All interviews with family members and nurses were conducted in the offices of head nurses and interviews with patients at the patient's bedside. All interviews were audio recorded by the recorder and then converted into written texts. The duration of the interviews was between 30 and 90 minutes. In addition to interviewing, in order to get a deeper understanding of the influential conditions and to confirm the data from the interviews, the researcher used the observation method to collect the data. The observation was performed by the researcher in various work shifts in the ward. After coordinating with the shift manager and obtaining permission from the patient, sometimes attended in the ward and the patient's room. In the observation process, the researcher observed the supportive behaviors of family members who were caring of the patient. The focus of the observation was on the support of family members and the content of supportive behaviors between the family members and the patient. Fourteen formal non-participatory observation sessions were conducted in this study. The duration of the sessions was between 5 to 75 minutes depending on the patient's conditions. The contents (field note) of each observation session were converted to written texts and then analyzed. The data collection was continued to saturation data so that in the last two interviews, the participants repeated

the same ideas with the information extracted from the previous interviews and observations, and no new concept was created. The data saturation concept is a state in which no new information is extracted from the data, and the categories evolve with respect to their maximum possible characteristics. The data analysis process was carried out according to the proposed steps of Graneheim and Lundman¹⁵ as follows:

The researcher converts interviews and observations into written texts. Texts were then read line by line by the researchers. Then codes were allocated to sentences and concepts. Words, sentences, and paragraphs were considered as semantic units. Semantic units were a collection of words and phrases that were related to each other by the content. So, these units were classified according to their content. Then the semantic units, according to their latent meaning, reached the level of abstraction and conceptualization and were named by codes. The codes were compared with each other in terms of their similarities and differences, and were categorized under more abstract categories with specific themes.¹⁵ Finally, the contents of the data were introduced as the subject matter of the study by comparing the categories with each other. Criteria such as credibility, transferability, confirmation, and dependability were used by the researcher to verify trustworthiness. Long-term engagement, check by the participants and the check and confirm by the three colleagues familiarity with qualitative research were used to increase the credibility of the study. The researcher conducted interviews and repetitive meetings with the participants for an in-depth understanding. In participatory check, a part of the text accompanied by the initial codes came to the participants' observation and the convergence degree of the researcher's extracted ideas from the data was compared with their observation. In, the concepts and categories created from the data were presented to the colleagues familiar with the qualitative research. Besides the main researcher, three other academic members also studied and confirmed the achieved results as external check. In case of disagreement between the colleagues and researcher, the data analysis and conceptualization were done again by the researcher, and results were returned to the colleagues until their approval and consensus was expressed. All crude data such as recorded tapes were maintained by the researcher. To increase transferability, the researcher proceeded to describe the study process in a precise manner. After performing the administrative procedures for introducing the researcher to the research environment, the researcher first explained the purpose of the study and its implementation to the participants, and after their agreement, they signed the consent form. During the observations, the consent form was received dynamically and continuously from the family members, nurses, and patients. The researcher was present in the waiting room and observed the supporting behaviors of

the family member with the patient.

Results

Twenty people participated in the study: 4 female nurses and 1 male nurse, 5 male and 3 female relatives, 4 male patients and 3 female patients. All nurses had a baccalaureate nursing degree, and a work experience of 4 to 25 years. Two of the nurses were head nurses and the rest were shift workers. Two of them also had a job in a private hospital. The family members were from the age range of 24 to 48. The participants were 42 to 75 years old. The details of all participants are presented in Tables 1, 2, and 3.

From the perspective of the participants, supportive behaviors included maintaining a strong attitude of care, obtaining reliable information from the nurse, seeking economic supportive resources, and giving feedback to the patients to improve the symptoms of their diseases. Participants' experiences reflected their patients' need for support. These experiences expressed in terms of three pivotal concepts: support by the therapeutic alliance, participatory information, and instrumental support (Table 4).

Table 1. Demographic data of the participants (nurses)

Work experience (year)	Education	Age (year)	Sex
4	Bachelor	30	Female
9	Bachelor	38	Female
25	Bachelor	48	Female
23	Bachelor	47	Female
20	Bachelor	43	Male

Table 2. Demographic data of the participants (family members)

Education	Relationship with patient	Age (year)	Sex
Associate degree	Child	38	Male
Diploma	Child	36	Female
Primary school	Brother	45	Male
Diploma	Husband	48	Male
High school	Sister	40	Female
Bachelor	Child	24	Female
Bachelor	Child	30	Male
Diploma	Child	27	Male

Table 3. Demographic data of the participants (patients)

Medical diagnostic	Education	Age (year)	Sex
Congestive heart failure	Secondary school	75	Male
Myocardial infarction	Diploma	49	Male
Acute coronary syndrome	Primary school	50	Female
Acute coronary syndrome	Diploma	46	Female
Myocardial infarction	Master	42	Male
Acute coronary syndrome	Bachelor	57	Male
Myocardial infarction	Illiterate	68	Female

Table 4. Main categories and sub-categories

Main categories	Sub-categories
Support by the therapeutic alliance	<ul style="list-style-type: none"> - Attempt to console and reassure - Restoration of self-confidence and reduction of patient's insensibility - Commitment to the patient - Visiting patient
Participatory information	<ul style="list-style-type: none"> - Getting trusted information from the nurse - Having an active role in providing and increasing meaningful information about the prognosis of the patient
Practical and instrumental support	<ul style="list-style-type: none"> - Searching for economic support sources - Providing the necessary equipment for the patient - Trying to do the right care with respect to the family culture

Support by the therapeutic alliance

Family is one of the most important sources of empathic support, especially in societies like Iran that are family-oriented and have a family-centered culture. This support, which emphasizes the unity of the therapy with the patient, includes understanding emotional issues of the patient; having verbal communication and care, such as listening, empathizing, making comfort; and replacing disability and dependence with valuable behaviors and empowerment strategies. This support leads to increased coping skills, rehabilitation of self-esteem, and reduction of inadequacy and negative feelings, resulting in increased self-control in the patient. Family's relations with the patient are based on encouragement, reassurance, enhancement of competence and merit, and empathic responses to the patient with better health outcomes. Participants' experiences about support by the therapeutic alliance were categorized in the four sub-categories: attempt to console and reassure, rebuild confidence and reduce patient insensibility, have commitment to the patient, and visit the patient. From the perspective of the participants, "trying to console and reassure" involves being strong and having strong spirits that support the patient. In this regard, a man whose wife was admitted to CCU stated: "In order to be able to support my patient in these difficult conditions, I must have a strong spirit and give the patient a sense of comprehension, console, and reassurance" (Participant F4).

The participants believe "restoring self-esteem and reducing insensibility" are other examples of support through health unification. These behaviors are in fact a kind of patience supporting the patient. The participants in this study attempted to rebuild confidence and reduce the patient's inadequacy and replace disability and dependency with the power of induction and empowerment strategies. In this case, a family member, whose father was hospitalized, stated: "Support and sympathy with a heart patient means not to mention to him the disabilities and the problems of the treatment and care... We should give him confidence rather than an insensitive feeling...to induce him that he is a valued person" (Participant F6).

Commitment to the patient was also another important source of support for fellows. One of the supportive behaviors is the commitment of family members.

Commitment is defined as a psychological state in the willingness to decide and to continue engagement. Behavioral commitment includes a sense of pleasure, commitment to support the patient, performance enhancement, and reduction of the stress and pressure on family caregivers.

In this regard, the third participant said: "As much as the staff-the nurses- care the patient and answer your questions...this will be supportive...Of course, I myself will meet all the needs of my patient as much as possible" (Participant N3).

Meeting a patient is another subcategory of empathic support. The meeting is in line with patient-centered care and supportive behaviors by family members. Due to the infrastructure and rules governing special sectors in a medical center, limited meetings occur in the CCU section. Meeting, in addition to reducing family anxiety, can play an important role in the recovery process. In this regard, one of the nurses said: "It is true that the meeting is not allowed in the CCU, but when one or two of the family members are visiting the patient, it reduces the anxiety and provides support for the patient. It also has effective role in the recovery process." (Participant N1).

Participatory information

In this study, the experiences and contributions of the participants in participatory information were categorized into two subcategories: "acquiring trusted information from the nurse" and "the active role in providing meaningful information about the patient's prognosis."

The participants of the study believe that nurses can help them have a true understanding of family members and provide them credible information. Nurses consider the conditions and benefits of the patient. Furthermore, receiving credible information will help the carers to calm down, and ultimately present better support to their patients. "One of the things that nurses do in support of the patient and family members is to understand their concerns. Nurses usually give us the right information about the patient" (Participant F6).

Participatory information includes advice, guidance, and giving information to the patient. The family members can improve the health of their patient by providing

valuable information to him/her about how this/her disease is treated and controlled. They can even provide useful information about the prognosis of the disease. In this regard, one of the participants stated: *"I support my patient by collecting information about the process of the disease, its symptoms and its treatment, and passing this information to him"* (Participant F8).

Practical or instrumental support

Practical or instrumental support includes giving direct services or material assistance to the patient. Assisting the patient in timely control and diagnosis of symptoms, the provision and receipt of medication, and assistance in daily activities or personal care are examples of practical support that the family can offer the patient. This category consists of three subcategories; the search for economic supportive resources, the provision of the necessary equipment for the patient, and an attempt to take proper care with respect to the family culture. A number of participants believed that a part of the support was to seek financial and economic resources and insurance assistance for the patient. In this regard, he stated: *"My dad who is in the CCU has an inadequate economic condition. We need to be supported by the insurance, and aid associations. These days, I've visited some of these associations..."* (Participant F2).

Although vital medicines are available in special sectors, especially in the CCU, participants in this study considered the availability of medicines and the provision of the necessary supplies for the patient by family members as an essential support. In this relation, a participant stated: *"The nurse suddenly called me and asked to provide a medicine for our patient quickly ... Or take it out of the pharmacy ... I sometimes even bring my meal to the hospital from home..."* (Participant F4).

In the CCU, the presence of a caregiver for long time is usually prohibited, but depending on the patient's conditions, sometimes older patients need a caregiver in this unit. Family members believe that they are trying to take the proper care in respect to the family culture. According to one of the participants: *"...My mother was always used to cleaning herself with water after urination. So, I cleaned her with a damp pad with due respect to the nurses and by their permission... This is a kind of support. That is how she feels better"* (Participant F6).

"...The daughter washed her sick mother's hand on the bed and put the food in her mouth..." (Observation).

Discussion

The participants' experiences of this study were categorized in the form of three core concepts of support including the therapeutic alliance, participatory information, and instrumental support. One of the family's functions for the patient was support by the therapeutic alliance. At the time of admission, the family members tried to support the patient due to his/her critical circumstances. Wetzig and Mitchell¹⁶ showed that support of the patient was one

of the family members' demands. One of the supportive measures taken by the family members in this study was to console and reassure the patient. Family members with a continuous presence in the intensive care unit and attention to the patient tried to console and reassure the patient. Moreover, family members in the Al-Mutair et al., study stated that their presence in the intensive care unit would increase the morale of the patient and strengthen his/her feelings of love and belonging.¹⁷ Additionally, Mckiernan and McCarthy indicated that being alongside the patient is considered as reassuring to him/her, so that the patient feels that someone is with him/her and supports him/her.¹⁸

The patient's being in critical condition and hospitalization in the intensive care unit caused concerns for family members. So, they felt committed to the patient, and one of their functions at this critical moment was to visit the patient and care of him/her. The results of Blom et al., showed that it was important for the family members of the patient hospitalized in the intensive care unit to attend this unit and to participate in the care process of their patient.¹⁹ Wetzig and Mitchell¹⁶ also revealed that family members need to engage in the care of the patient physically. In Al-Mutair et al., study, it was important for the family members to stay alongside the patient because they wanted to be close to the intensive care unit to see the patient repeatedly and to know their patient's condition at any moment and to be able to meet him at any time.¹⁷ Moreover, Frivold et al., demonstrated that presence in the patient's bedside indicates the participation of the family members in the care process.²⁰

Another function of family members was to provide supportive care to patients through participatory information. One of the actions of family members in this regard was to receive reliable information from the nurse. Due to the fact that the patient was hospitalized in the intensive care unit and the family had lack of information on the conditions and treatment of the patient; so, family members were trying to receive reliable information from the nurse. Nurses were one of the important sources of information received by family members due to full-time attendance at the patients' bedside and awareness of the treatment process and patients' conditions. Carlson et al., indicated that family members' information needs were not fully met by the staff and they needed to receive further information.²¹ In several studies, family members have stated that they need to receive honest information about the patient. The results of Blom et al., study showed that giving honest information to family members by the staff creates a sense of responsibility in providing patient care.¹⁹ Wetzig and Mitchell also found that family members needed to have honest and understandable information.¹⁶ Patient's education and awareness can reduce their worries and stress and enable them to participate in their caring process.²² One way to get information about the patient's conditions is the family members' attendance in

the doctors and nurses' visiting of the patient. Au et al., indicated that family members had positive experiences with their participation in the doctors and nurses' round of their patient. They got information during the round and had an opportunity to get the answer of their questions. They also had the chance to share information about the patient with doctors and nurses.²³

Among the information that the family members sought to achieve in this study were awareness of the patient's prognosis because of the patient's presence in the intensive care unit and the acute and critical conditions of the disease. Frivold et al., indicated that many of the concerns experienced by relatives of patients were related to the patient's condition and prognosis. The patient's relatives wanted to know what had happened to the patient.²⁰ Family members were seeking information in this regard because they were not routinely provided with information. The results of the Al-Mutair et al., study also indicated that the family was seeking honest information, regardless of the good and bad news.¹⁷ Family members need information about medicines, vital signs, surgical procedures, or any procedures performed for their patient. In the Keenan and Joseph study, family members also needed information about the patient's conditions and prognosis.²⁴ Hsiao et al., and Sayin & Aksoy also indicated that family members were worried about caring of their patients and were interested in receiving information about the care procedures.^{25,26}

Family members, in spite of their own need for support from health care workers, tried to have an instrumental support of their patients. One of the supporting functions of family members was the search for economic supportive resources. Family members needed economic support due to hospitalization costs and, in some cases, patient's bad economic conditions, and were in the process of receiving this kind of support. The Wetzig and Mitchell study also found that family members needed different supports, such as financial one.¹⁶ In the study of Al-Mutair et al., family members stated that their needs were not met and they were not aware of the available community services in the hospital.¹⁷ Also, the results of the Babaei et al., study revealed that charity organizations can not cover all people in the community, or their contributions are not sufficiently effective to meet the needs of patients.¹²

One of the other functions of the family was to offer the right care. Family members tried to provide their patients with cares based on the family culture. The results of the Al-Mutair et al., study showed that many family members wanted to have contributions in the care process and thought that they were able to support the patient and create a sense of calm in the patient by their presence.¹⁷ Blom et al.,¹⁹ and Wetzig & Mitchell¹⁶ showed that it was important for family members to have contributions in the care process of their s who were in the ICU. Moreover, Frivold et al., demonstrated the active role of family members in the routine care of the patient.²⁰

Conclusion

In order to strengthen the family's supportive behaviors, special attention needs to be paid to their psychological, physical, and financial conditions during the care of their admitted patients in the CCU. Furthermore, family members need to adapt themselves to the current conditions for an effective support of their patients. Some of them try to support their patients through the therapeutic alliance, some other through participatory information, and some by instrumental tools. Nurses play an important role in training family members about how to care and support patients. They can also encourage family members to help and support their patients by establishing appropriate and solid communication during the care process with them, providing information and opening their mental nodes, and paying particular attention to strengthen their supportive behaviors. Also, the results of this study can be used by researchers, managers, and planners to make decisions based on supportive, caring, and evidence-based treatment needs. This study was limited to the family members of the special cardiology unit. Thus, it is suggested to conduct research separately in the ICU, neurology, trauma, and respiration units, as the supporting behaviors of family members in other units can be different of their behaviors in the present study.

Acknowledgments

We appreciate all the participants in this study who had collaborated in the production of information, also of the University of Medical Sciences Isfahan for financial support and underlying the field of study, sincerely thank them.

Ethical Issues

The Ethics Committee of Isfahan University of Medical Sciences approved the study (No. 296144).

Conflict of Interest

The authors declare no conflict of interest in this study.

Research Highlights

What is the current knowledge?

Nurses should consider family's supportive care of the patient admitted to the CCU as an important component of patient-centred care. Family's supportive care of the patient should be considered in nursing and practical educational programmes. To develop the family's supportive care of the patient, it is vital to make changes in the dominant philosophy and culture of caring environments. Nurses should receive appropriate training with focus on family and patient-centred approaches.

What is new here?

Family's supportive care of the patient plays an important role in the quality of patient care. Family's supportive care of the patient in health centres should be routine. Furthermore, family's supportive care of the patient can improve working environments and empower nurses to offer high-quality care.

Author's Contributions

Study conception and design, data collection and Critical revision of the article: SB; Data analysis and interpretation: SB and SA; Drafting of the article; SB and SA.

References

- Najafi Ghezljeh T, Emami A. Strategies for recreating normal life: Iranian coronary heart disease patients' perspectives on coping strategies. *J Clin Nurs*. 2014; 23(15-16): 2151-60. doi: 10.1111/jocn.12428
- Honea NJ, Brintnall R, Given B, Sherwood P, Colao DB, Somers SC. Putting Evidence into Practice: nursing assessment and interventions to reduce family caregiver strain and burden. *Clin J Oncol Nurs*. 2008; 12(3): 507-16. doi: 10.1188/08.cjon.507-516
- Smeltzer SC, Bare BG, Hinkle JL, Cheever KH. Brunner and Suddarth's Textbook of Medical Surgical Nursing. 12th ed. Philadelphia: Lippincott Williams & Wilkins; 2010.
- Maina PM, Kimani S, Omuga B. Involvement of Patients' families in care of critically ill patients at kenyatta national hospital critical care units. *Am J Nurs Sci* 2018; 7(1): 31-8. doi: 10.11648/j.ajns.20180701.14
- Khosravan S, Mazlom B, Abdollahzade N, Jamali Z, Mansoorian MR. Family participation in the nursing care of the hospitalized patients. *Iran Red Crescent Med J*. 2014; 16(1): e12686. doi: 10.5812/ircmj.12868
- Kloos JA, Daly BJ. Effect of a Family-Maintained Progress Journal on anxiety of families of critically ill patients. *Crit Care Nurs Q*. 2008; 31(2): 96-107. doi: 10.1097/01.CNQ.0000314469.41507.cb
- Vellone E, Chung ML, Alvaro R, Paturzo M, Dellafiore F. The influence of mutuality on self-care in heart failure patients and caregivers: a dyadic analysis. *J Fam Nurs*. 2018; 1074840718809484. doi: 10.1177/1074840718809484
- Bailey JJ, Sabbagh M, Loiselle CG, Boileau J, McVey L. Supporting families in the ICU: a descriptive correlational study of informational support, anxiety, and satisfaction with care. *Intensive Crit Care Nurs*. 2010; 26(2): 114-22. doi: 10.1016/j.iccn.2009.12.006
- Kaakinen JR, Coehlo DP, Steele R, Robinson M. Family health care nursing: theory, practice, and research. 6th ed. Philadelphia: F.A. Davis Company; 2018.
- Masoodi R, Alhani F, Moghadassi J, Ghorbani M. The effect of family-centered empowerment model on skill, attitude, and knowledge of multiple sclerosis caregivers. *Journal of Birjand University of Medical Sciences*. 2010; 17(2): 87-97. [Persian]
- Rahimi Kordshooli K, Rakhshan M, Ghanbari A. The effect of family-centered empowerment model on the illness perception in heart failure patients: a randomized controlled clinical trial. *J Caring Sci*. 2018; 7(4): 189-95. doi: 10.15171/jcs.2018.029
- Babaei S, Taleghani F, Kayvanara M. Compassionate behaviours of clinical nurses in Iran: an ethnographic study. *Int Nurs Rev*. 2016; 63(3): 388-94. doi: 10.1111/inr.12296
- Ravi S, Kumar S, Gopichandran V. Do supportive family behaviors promote diabetes self-management in resource limited urban settings? a cross sectional study. *BMC Public Health*. 2018; 18(1): 826. doi: 10.1186/s12889-018-5766-1
- Streubert HJ, Carpenter DR. Qualitative research in nursing. 5th ed. Philadelphia: Wolters Kluwer; 2011.
- Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004; 24(2): 105-12. doi: 10.1016/j.nedt.2003.10.001
- Wetzig K, Mitchell M. The needs of families of ICU trauma patients: an integrative review. *Intensive Crit Care Nurs*. 2017; 41: 63-70. doi: 10.1016/j.iccn.2017.02.006
- Al-Mutair AS, Plummer V, Clerehan R, O'Brien A. Needs and experiences of intensive care patients' families: a Saudi qualitative study. *Nurs Crit Care*. 2014; 19(3): 135-44. doi: 10.1111/nicc.12040
- McKiernan M, McCarthy G. Family members' lived experience in the intensive care unit: a phenomenological study. *Intensive Crit Care Nurs*. 2010; 26(5): 254-61. doi: 10.1016/j.iccn.2010.06.004
- Blom H, Gustavsson C, Sundler AJ. Participation and support in intensive care as experienced by close relatives of patients: a phenomenological study. *Intensive Crit Care Nurs*. 2013; 29(1): 1-8. doi: 10.1016/j.iccn.2012.04.002
- Frivold G, Dale B, Slettebø Å. Family members' experiences of being cared for by nurses and physicians in Norwegian intensive care units: a phenomenological hermeneutical study. *Intensive Crit Care Nurs*. 2015; 31(4): 232-40. doi: 10.1016/j.iccn.2015.01.006
- Carlson EB, Spain DA, Muhtadie L, McDade-Montez L, Macia KS. Care and caring in the intensive care unit: family members' distress and perceptions about staff skills, communication, and emotional support. *J Crit Care*. 2015; 30(3): 557-61. doi: 10.1016/j.jcrc.2015.01.012
- Babaei S, Taleghani F. Compassionate care challenges and barriers in clinical nurses: a qualitative study. *Iran J Nurs Midwifery Res*. 2019; 24(3): 213-9. doi: 10.4103/ijnmr.IJNMR_100_18
- Au SS, Roze des Ordon A, Soo A, Guienguere S, Stelfox HT. Family participation in intensive care unit rounds: comparing family and provider perspectives. *J Crit Care*. 2017; 38: 132-6. doi: 10.1016/j.jcrc.2016.10.020
- Keenan A, Joseph L. The needs of family members of severe traumatic brain injured patients during critical and acute care: a qualitative study. *Can J Neurosci Nurs*. 2010; 32(3): 25-35
- Hsiao PR, Redley B, Hsiao YC, Lin CC, Han CY, Lin HR. Family needs of critically ill patients in the emergency department. *Int Emerg Nurs*. 2017; 30: 3-8. doi: 10.1016/j.ienj.2016.05.002
- Sayin Y, Aksoy G. The nurse's role in providing information to surgical patients and family members in Turkey: a descriptive study. *AORN J*. 2012; 95(6): 772-87. doi: 10.1016/j.aorn.2011.06.012
- Babaei S, Taleghani F, Kayvanara M. Compassionate behaviours of clinical nurses in Iran: an ethnographic study. *Int Nurs Rev*. 2016; 63(3): 388-94. doi: 10.1111/inr.12296